Approved, SCAO

Original - Obligor
1st copy - Requesting party
2nd copy - for court as needed

STATE OF MICHIGAN 50th. JUDICIAL CIRCUIT Chippewa COUNTY	REQUEST FOR HEALTH CARE EXPENSE PAYMENT	CASE NO.

Friend of the Court address
300 Court Street, Sault Ste. Marie, MI 49783

Telephone no.
(906) 635-6347

Plaintiff

v

Defendant

INSTRUCTIONS FOR REQUESTING PARTY:

The following is important information should you later seek to obtain the friend of the court's help to enforce payment of health care expenses (medical, dental, and other health care expenses).

1. Your court order must require the other party to pay a portion of health care expenses.
2. The expense must exceed any amounts your child support order requires as a prerequisite for enforcement.
3. You must submit your request for payment to the other party within 28 days of either the date insurance has paid on the expenses or the date insurance denies payment.
4. If you and the other party reach an agreement concerning the expenses, the agreement must be in writing, list the expenses to be paid, state the total amount to be paid, and provide a schedule for payment. Both parties must sign the agreement.
5. The bills must be presented to the friend of the court on or before the following: 1 year after the expense was incurred; or 6 months after the insurer's final denial of coverage for the expense (as long as all measures necessary to submit the claim to insurance were completed within 2 months after the expense was incurred); or 6 months after a default in a repayment agreement as set forth above. You will need to fill out a second form to request enforcement.
6. In the event it is necessary for the friend of the court to enforce payment of the expenses, you must have supporting bills and receipts for the expenses you list. You will be responsible for establishing the expenses and their necessity. Please bring your documentation to all court hearings where medical expenses may be discussed.
7. Attach a copy of all bills and insurance notifications to this form.
8. **You must keep a copy of this form and all attachments for the friend of the court to use in the event enforcement action is necessary.**

TO: Obligor's name and address

Complete expenses incurred on the other side of this form.

The following expenses have been incurred for the health care of a minor child for whom you are obligated to provide health care support.

Name of Child Receiving Service	Name of Medical Provider	Date of Service	Type of Service	Total Medical Cost	Amt. Paid by Insurance	Balance Due*	Obligor's %	Amt. Owed by Obligor

I declare that the above statements are true to the best of my information, knowledge, and belief and that on this date I mailed a copy of this Request for Health Care Expense Payment to the obligor at his or her last known address.

_____ Date

_____ Signature

*Balance due means balance owed after payment by insurance and any adjustments to the total medical cost.

Approved, SCAO

Original - Court
1st copy - Obligor

2nd copy - Requesting party
3rd copy - FOC file

STATE OF MICHIGAN 50th. JUDICIAL CIRCUIT Chippewa COUNTY	COMPLAINT FOR ENFORCEMENT OF HEALTH CARE EXPENSE PAYMENT	CASE NO.

Friend of the Court address
300 Court Street, Sault Ste. Marie, MI 49783

Telephone no.
(906) 635-6347

Plaintiff

v

Defendant

TO: Obligor's name and address

Notice to Obligor:
Under MCL 552.511a, the friend of the court has been asked to enforce the health care expenses described below. Unless you file a written objection with the friend of the court within 21 days of the date provided in MCL 552.511a, the expenses will be added to your support account as a health care support arrearage for enforcement and must be paid ☐ in full by _____. ☐ $_____ per month, except that the full balance will be subject to immediate enforcement.
If you timely file a written objection in the manner required, a hearing will be set to resolve the health care complaint.

I certify that on this date I mailed a copy of this complaint to the obligor by ordinary mail to the obligor's last known address.

_____
Date

_____
Friend of the court/Authorized representative

Requesting Party's Statement:

I request the friend of the court to enforce health care expenses. Attached is the request for Health Care Expense Payment (including all supporting documents) given to the obligor. **I declare that:**

1. I requested payment within 28 days of the date notified of the balance due after insurance payments.

2. This request is for expenses that are more than the minimum amount my order requires for enforcement.

3. This complaint is
   - ☐ within 6 months after the date of the insurer's final denial of coverage for the expense.
   - ☐ within 1 year of the date the expense was incurred.
   - ☐ within 6 months after the obligor's default of an agreement to repay (copy of agreement attached).

4. As of this date, the expense information in the attached Request for Health Care Expense Payment is true except as follows:

   Since the date I mailed the Request for Health Care Expense Payment to the obligor, the obligor paid $_____

   for _____ and _____.
   Name(s) of child(ren) — Name(s) of medical provider(s)

I declare that the above statements are true to the best of my information, knowledge, and belief.

_____
Date

_____
Signature